PRINTED: 06/04/2010 FORM APPROVED Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS5303AGC 11/02/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7955 TRAIL HEAD DR ADDIE'S HOME CARE, INC LAS VEGAS, NV 89113 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual state licensure survey conducted in your facility on 11/2/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The facility received a survey grade of D. The following deficiencies were identified: 449.200(1)(d) Personnel File - NAC 441A / Y 103 Y 103 SS=F **Tuberculosis** NAC 449.200

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

 Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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ADDIE'S HOME CARE, INC			7955 TRAIL HEAD DR LAS VEGAS, NV 89113						
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Y 103	Continued From page 1			Y 103					
	This Regulation is not met as evidenced by: Based on interview and record review on 11/2/09, the facility failed to ensure 2 of 3 employees complied with NAC 441A.375 regarding tuberculosis (TB) testing for the protection of all residents (Employee #1 and #3)								
	Severity: 2 Scope:	3							
Y 105 SS=F	449.200(1)(f) Personnel File - Background Ch		heck	Y 105					
	a separate personne member of the staff of	se provided in subsection I file must be kept for ea of a facility and must inc Iiance with NRS 449.17	ach lude:						
	Based on record revi	ot met as evidenced by: lew on 11/2/09, the facil 2 caregivers met backgi (Employee #2, FBI repo and Criminal History	ity ound						
	Severity: 2 Scope:	3							
Y 274 SS=C	449.2175(5) Service	of Food - Substitutions		Y 274					
	be documented and at least 90 days after	or an item on the menu kept on file with the men the substitution occurs posted in a conspicuous	nu for . A						

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLI IDENTIFICATION NU				(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED			
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ADDIE'S HOME CAPE INC. 7955 T			7955 TRAIL	DDRESS, CITY, STATE, ZIP CODE AIL HEAD DR GAS, NV 89113					
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Y 274	Continued From page 2 place during the service of the meal.  This Regulation is not met as evidenced by: Based on observation and interview on 11/2/09, the facility failed to ensure menu substitutions were documented and retained for at least 90 days. The facility failed to follow the posted menu for 2 of 2 meals observed in the facility. The facility failed to document the substitutions.			Y 274					
Y 444 SS=F	NAC 449.229  9. Smoke detectors must be maintained in proper operating conditions at all times and must be tested monthly. The results of the tests pursuant to this subsection must be recorded and maintained at the facility.  This Regulation is not met as evidenced by: Based on record review on 11/2/09, the facility failed to ensure all smoke detectors were tested 12 out of the past 12 months. The facility failed		e suant : : lity sted	Y 444					
Y 451 SS=F	had been checked en Severity: 2 Scope:	3	ors	Y 451					

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5. An over-the-counter medication or a dietary supplement may be given to a resident only if the

administration of the medication or supplement in writing or the facility is ordered to do so by another physician. The over-the-counter medication or dietary supplement must be administered in accordance with the written

resident's physician has approved the

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This Regulation is not met as evidenced by: Based on record review and interviews on 11/2/09, the facility had no evidence physicians were notified within 12 hours when 2 of 5 residents refused or missed their medications

(Resident #4 and #5).

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449.2749(1)(e) Resident file-NRS 441A

Y 936

Tuberculosis

SS=F

Y 936

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.